

ANNOTATED BIBLIOGRAPHY

of documents relevant to provider behavior in Egypt

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for The CHANGE Project and HM/HC, January 2001*

Introduction

Although the patient-provider interaction has been studied extensively, relatively few studies examine the interaction from the point of view of the provider. The literature from the United States on physician job satisfaction tends to explore issues such as changes in insurance, laws, and practice conditions and their effects on providers. However, some concepts used by medical sociology to explore provider behavior in the West may also have application to Egypt, e.g., professional dominance and professional autonomy.

This annotated bibliography focuses on physician behavior and explanations for it. It begins with quantitative studies from Egypt, then turns to case studies from elsewhere in the developing world that include results and concepts that may be applicable to Egypt. Finally, the bibliography explores patient outcomes and physician behavior. The summary section pulls out the most relevant findings from the literature and discussions with HM/HC staff, as well as concepts that may help to focus CHANGE-HM/HC partnership activities.

Egypt

Ministry of Health of Egypt Child Survival Project, in cooperation with the United States Agency for International Development

**July 1994 National Maternal Mortality Study: Findings and Conclusions.
Cairo: Ministry of Health Child Survival Project.**

The Child Survival Project was an earlier form of what is now the Healthy Mother/Healthy Child Project (HM/HC). The Child Survival Project conducted a national study of maternal mortality, with data collected from March 1, 1992 to February 28, 1993. These research results guided the development of the package of current interventions under the HM/HC results package. The authors divided causes of maternal death into direct, indirect, and unknown. Direct causes included hemorrhage, hypertensive diseases, and other (which covered both potential provider errors – e.g., anesthesia, as well as unpreventable causes – e.g., pulmonary embolism). Indirect causes included a variety of conditions, (e.g., anemia, neurological disorders, neoplasms, diabetes). Of the 718 maternal deaths of known causes that were collected in the study, analysis suggested that 92 percent were avoidable. Of the avoidable deaths, 47% were due to poor diagnosis and management by the obstetrical team. A category that the authors term “patient factors” was responsible for another 42% of deaths (e.g., delay in seeking care or non-compliance with medical advice). Difficulty in obtaining blood for hemorrhaging women was responsible for 6% of the maternal deaths. Dayas (traditional

birth attendants) were reported by the DHS II to deliver 59.3% of women, but in this study sample, dayas could have prevented only 12% of the deaths.

Delivery of poor antenatal care and lack of antenatal care were considered in one analytical category. The results suggest that adequate antenatal care could have prevented about one-third of the maternal deaths. Of those women whose deaths could have been averted with provision of antenatal care, 40% had received sub-standard antenatal care. In addition to misdiagnosis and poor case management, the study also suggests that providers' lack of knowledge or disregard for the life situation of their patients may have led to unrealistic medical advice which patients were unable to comply with, to their peril.

Nandakumar, A.K., Peter Berman, and Elaine Fleming

May 1999 Technical Report No. 26. Findings of the Egyptian Health Care Provider Survey. Bethesda, MD: Abt Associates.

Conducted under the USAID Data for Decision-Making Project (DDM), the report presents the results of five surveys: 1. Health care institutions, 2. Private clinics, 3. Pharmacies, 4. Dayas, and 5. Other practitioners (e.g., nurses). Facilities and providers were surveyed in four each of the following categories of governorates: urban, Lower Egypt, and Upper Egypt. Upper Egypt survey sites were located in Qena, Beni Suef, Assiut, and Giza. Physicians came from all specialties. A total of 10,048 providers were sampled, which included looking at 537 facilities. The study emphasized private practitioners. Pharmacists, dentists, and nurses practicing privately were reported on separately.

The most important findings relevant to the context of physician behavior include:

- Facilities – public, private, and parastatal—employ both full-time and part-time physicians.
- The vast majority of private physicians (89%) have more than one job, usually in the public sector.
- Physicians spend long hours in their private clinics.
- Obstetrician-gynecologists are among the lowest paid private physicians, with a mean monthly income from their clinics of LE 730 and a median income of LE 300 (compared to the highest paid specialists, psychiatrists, with a mean monthly income of LE 2,517 and a median monthly income of LE 1,100).
- Only 2% of private physicians practicing in the rural Upper Egyptian governorates included in the study are women.
- Of the 127 obstetrician-gynecologists sampled, 28 are women, making it the second most popular specialty for female physicians (exceeded only by pediatrics).
- Obstetrics and gynecology (ob-gyn) is the second most popular specialty for private physicians (14% of the private physicians sampled specialized in ob-gyn) – only surgery had more specialists (16%).

- Private physicians (aggregate response for all specialties) average about 20 minutes with each patient in their private clinics.
- Forty-three percent of private clinics always keep files on the medical history of their patients; an equal percentage never keep files.
- More than half of the private physicians in rural Upper Egypt wanted to have more patients; in urban Upper Egypt, slightly less than half the physicians felt this way.
- About one-third of the private physicians subscribed to medical journals; however in rural Upper Egypt, the percentage was only 13; in urban Upper Egypt, 37% said they subscribed to medical journals.
- The majority of physicians said they learn new information through books, followed by training.

Aspects of facilities that might contribute to or reflect provider attitudes include:

- Only 88% of MOHP inpatient facilities maintain patient records (the data are an aggregate of all inpatient departments).
- The majority of surveyed providers in MOHP facilities believe that patients prefer their facility due to the low cost (79%), followed by proximity to the patient's residence (57%); good quality service was cited by 28% of the MOHP providers.
- Survey researchers observed and rated facility cleanliness, personnel attitude and uniform, personnel's manner toward patients, and the ease with which attendants dealt with various services – data were reported by institution (e.g., MOHP, CCO, HIO, etc.); the rating criteria were not explained in the report.
- 57% of MOHP facilities rated "good" or "very good" for cleanliness, 6 rated "unsatisfactory;" the remainder were "satisfactory."
- In personnel attitude and uniform, 56% of MOHP facilities were rated very good or good, with 42% satisfactory and 1 "unsatisfactory."
- Regarding interviewers' perceptions of how personnel behaved with patients, MOHP facilities rated 62% good or very good, 37% satisfactory, and 1% satisfactory.

The study surveyed dayas and found that:

- Dayas are older women, usually in their mid fifties and 70% of the sample were illiterate.
- All but 11% of the sample were trained informally by relatives or colleagues.
- All deliver babies; 83% reported providing postnatal care and 37% of rural Upper Egyptian dayas, and 57% of urban Upper Egyptian dayas reported providing antenatal care [responses to post and prenatal care may be a factor of the way the questions were phrased, which was not reported in the results].
- An odd and unexplained finding is that only 7% of dayas in rural Upper Egypt and 14% in urban Upper Egypt reported providing circumcision; the study did not ask about services such as *dokhla baladi* [manual defloration, usually by a daya].
- Another unexpected finding was that "nearly all dayas wash their hands and arms with soap and water prior to the delivery. Approximately three-quarters of the sample boil and sterilize their instruments. Almost half of the sample prepares water with antiseptic for later use."

- The average number of deliveries per day per month was highest in Upper Egypt: 12 in rural areas and 11 in urban areas.
- Overall, 68% base their fees on the ability of the family to pay. 80% of the rural Upper Egyptian dayas and 71% of the urban Upper Egyptian dayas reported using a sliding payment scale.
- Unlike others surveyed, 74% of the dayas reported job satisfaction.
- 79% of dayas attributed their ability to attract patients to women's perception of their experience and success; 70% said that the women knew them and 47% reported that women come to dayas because they are less expensive than physicians.

El-Mehairy, Theresa

1984 Medical Doctors. A Study of Role Concept and Job Satisfaction. The Egyptian Case. Leiden:E.J. Brill.

During the 1980s, Theresa El-Mahairy, a sociologist, conducted studies in several areas of Egypt on physicians' concepts of their role, professionalism, and job satisfaction. In the 1980s, the Ministry of Health of Egypt (MOH) was concerned about health outcomes in its facilities, the behavior and job satisfaction of its physicians, as well as health system issues.¹ The MOH began to examine these issues. A sample of MOH physicians filled out questionnaires that addressed major factors that they thought acted as impediments to doing their jobs. Most of the challenges that the MOH physician sample mentioned continue to be issues today. In addition, medical students filled out a questionnaire. Survey instruments included questions about values. An Egyptian social scientist developed a value scale for the study.

The physician sample included 136 physicians from El Minia (N=50), Menoufia (N=50), and Cairo (N=36) governorates. The medical student sample included 105 fourth and fifth year students at Ain Shams Faculty of Medicine.² Physicians from the Upper Egyptian governorate (El Minia) and Lower Egyptian governorate (Menoufia) samples worked as heads of Rural Health Units, while the Cairo sample included residents and senior physicians.

To put the study in context, in the mid-1980s, the government of Egypt and USAID gathered a small group of MOH leaders and American social scientists and consultants. This group ranked what they thought were the most important challenges facing MOH physicians. Although there was quite a bit of individual variation in rankings, American answers tended to resemble each other more than they did Egyptian answers. Similarly, Egyptian answers tended to resemble each other more than they did American answers. Whether this was due primarily to a physician/social scientist distinction, MOH/non-MOH differences or Egyptian/American differences, or whether to some combination

¹ In the mid 1990s, political reshuffling of cabinet positions resulted in a change of name from the MOH to the Ministry of Health and Population (MOHP).

² Egypt follows the European model of medical education. Students enter the university medical faculty directly after high school. They graduate from the medical faculty after five years with a Bachelors of Medicine (M.B.) and Bachelors of Surgery (B. Ch.).

was not clear because no Egyptian social scientists or non-physician MOH staff were involved. However, this result is crucial for CHANGE and HM/HC because it suggests that it is essential that the behaviors and issues raised need to be decided upon and negotiated jointly between Egyptian and expatriate HM/HC staff, MOHP decision makers, and CHANGE staff.

El-Mehairy cites results from a 1978 MOH study of patient reactions to government hospitals. Patient reactions to public sector hospitals seem to have changed little. The MOH study found:

- Criticism of attitudes of doctors, nurses, and other para-medical staff toward patients
- Absence of physicians on call during working hours, resulting in very long waits
- Improper quality and quantity of meals offered to patients in hospitals
- Complaints about hospital buildings, lodging facilities, sanitation, and other services
- Referral by some physicians of their private cases to public hospitals, with more attention paid to these patients than those admitted from out-patient clinics.

One of the complaints mentioned by this study has been remedied: there is no longer an insufficient number of hospital beds, necessitating long waits for hospital admission. (MOH, ARE, Health Profile of Egypt, Public Opinion Towards Health Services, Memo Number 2, May 1978)

El-Mehairy explains the results of her physician and medical student survey with an eclectic variety of theoretical frameworks. Perhaps the most prevalent frameworks are derived from role theory and neo-Parsonian models. The author also places Egyptian physician behavior in historical context: the first two Egyptian hospitals (both in Cairo) were built in 1799, under French occupation. Both disintegrated with the departure of the defeated French. In 1827, a European professor established a western biomedical school in Egypt. The medical school (which in 1837 shifted location to the present site of Cairo University Hospital, Kasr El Aini, also the site of the Medical Faculty) was run by European professors until 1858, when Europe-educated Egyptian faculty members took over. During occupation, the British took control of the medical school and hospital. Modern Egyptian notions of professionalism, and medical professionalism arose during this colonial period. Many intellectuals (physicians among them) responded to colonial rule by deciding that since Egypt could not rid the country of a European power, they should try to profit from the European presence. The colonial administration made medicine, as well as other professions, dependent on their administration for social and economic rewards. The client physicians were encouraged to share the view of the colonial patrons, who discouraged experimentation and research. In addition, the main accountability was to the colonial patron, rather than to the indigenous patient. After colonial dominance disappeared, the state replaced the colonial power in its corporate patronage of the profession of medicine. The historical circumstances produced trends that endure into the present. The most important of the trends are lack of professional autonomy within the MOH system and the low level of professional dominance of physicians in Egypt.

In El-Mehairy's survey, key results of the practicing physician sample include:

- Major differences in physician response between Lower Egypt (Menoufia) and Cairo, in comparison to Upper Egypt (El Minia) in many areas.
 - 62% of the Menoufia sample and 53% of the Cairo sample felt that their university education had adequately prepared them for their profession, while only 34% of El Minia respondents agreed.
 - Upper Egyptian physicians reported that an important part of their role was acting as mediator in village disputes and participating in meetings of local government.
 - Physicians working in Upper Egypt were much more likely to have graduated from an Upper Egyptian medical school (regardless of where they were raised).
- There was agreement across sites that the physician's role is primarily to provide medical care (between 84-92% of the sample).
- Physicians' complaints included the following:
 - Bureaucracy
 - Conditions of work, isolation, hours (60% of El Minia sample; only 42% of Menoufia sample)
 - Managerial responsibilities, bookkeeping (80% of El Minia sample, and 90% of Menoufia sample)
 - Lack of equipment and supplies (at 80%, highest in El Minia)
 - Inadequate staff (El Minia 64%, while in Cairo 22% mentioned this and only 12% in Menoufia)
 - Cost of living complaints were highest in Cairo and Menoufia (72% each) and lowest in El Minia (46%).
- The Upper Egyptian sample responded to questions about causes of satisfaction: 92% checked "relationships with colleagues," 90% marked "job fulfillment," 90% marked "family relationships," and 86% marked "contribution to the health and welfare of the people."
- The least important source of satisfaction in all sites was "promotional opportunities," (6% Cairo, 4% Menoufia, 16% El Minia) followed by "financial rewards" (6% Cairo, 4% Menoufia, 22% El Minia).
- Respondents from El Minia marked almost all choices as higher sources of satisfaction than sample members from the other sites, either indicating that doctors in El Minia were more satisfied or tended to fill out questionnaires in a different way from physicians from other sites.
- Respondents in El Minia also reported higher levels of dissatisfaction in most items—the author seeks to explain this seeming paradox through the theory of cognitive dissonance and theories of role adaptation.
 - The majority of Cairo physicians reported difficulty with subordinates' discipline, while few Upper Egyptian physicians reported the problem; about 1/3 of Lower Egyptian physicians reported this difficulty.
 - The majority of Upper Egyptian physicians reported difficulty with subordinates' lack of responsibility, while few Cairo physicians reported this; about 1/4 of Lower Egyptian physicians reported this.
 - Physicians complained that nurses and lower level staff did not have sufficient training; some said that physicians should be trained in how to train nurses.

Key results of the student survey include:

- Only 56% viewed mandatory village service as a means for serving others; 50% viewed it as a valuable experience.
- Only 30% had ever been to a rural health unit.
- 75% felt that their education was not adequately preparing them to work in rural areas.
- 77% responded that villagers did not share the same cultural background as they did.
- When asked to describe the “world view” of villagers, most mentioned negative traits (e.g., witchcraft, limited health awareness, high fertility rate, misunderstanding of religion, poverty, illiteracy).
- 78% would decline to stay in a rural area after the end of their service.
- When compared to the physician sample, it appeared that students’ anticipation of dissatisfaction with practice conditions after graduation were largely accurate.
- Students tended to greatly underestimate the disadvantages of managerial responsibilities and bookkeeping.

The author concludes with recommendations for medical training. For example, medical students “should receive some instruction in the techniques of teaching and training subordinate personnel, stressing the team approach...”(188). She feels that a course in rural health care should be offered to medical students in their fifth year. She also concludes that Parsonian role theory must be greatly modified to apply to Egypt.

Client Perspective

Kabakian-Khasholian, Tamar, Oona Campbell, Mona Shediach-Rizkallah, and Françoise Ghorayeb

2000 Women’s Experiences of Maternity Care: Satisfaction or Passivity? *Social Science and Medicine* 51(2000): 103-113.

The study examined provider behavior from the researchers’/women’s perspectives. The sample of 117 women was drawn in Lebanon from two remote villages, a semi-rural area, and urban areas of Beirut. The sample contained both poor rural women and well-heeled urbanites. Women were interviewed with an open-ended interview schedule.

The study provides an example of another Middle Eastern country in which some of the maternal health challenges that Egypt faces have begun to change (e.g., use of antenatal and post-partum care). The study provides a snapshot of change in progress and should be encouraging to Egyptian public health managers attempting to make similar changes. In addition, many of the feelings and experiences voiced by Lebanese women resemble those found in data from Egypt.

Results indicated that

- Women chose their provider based on previous experience or word of mouth from other women.
- Rural women avoided public sector physicians if they felt they were not treated humanely and went to midwives.

- Many rural and urban women preferred female obstetricians or midwives to provide pregnancy care.
- Among rural women, preference for delivery by a physician and in a hospital could overcome reluctance to use a male physician.
- In case of any complication, many women preferred male obstetricians because they regarded them as more skilled.
- Women in rural areas viewed antenatal visits as necessary only if there was a problem or if the woman was particularly concerned, but urban women (who were also much wealthier) had regular prenatal visits, even when these visits were a financial drain.
- Both urban and rural women based their level of satisfaction during the antenatal period on how much time the provider spent listening to their concerns and questions; however this was not a factor for women in very remote areas who had to travel far and spend more money to see a provider.
- The “vast majority” of primiparas mentioned that they received insufficient information about procedures during labor and delivery.
- Women in all categories were satisfied with the information they received prior to labor.
- Women in all areas “highly appreciated” their husbands’ help with household chores, child care, as well as provision of emotional support during pregnancy.
- Women in all areas preferred to wait until labor was advanced before going to the hospital; although they preferred to deliver in hospital, they preferred to leave the hospital within 24 hours after delivery.
- When the obstetrician, midwife, or medical staff praised or encouraged the woman during labor and delivery, women were very grateful and felt encouraged
- Women delivering in teaching hospitals complained about the lack of privacy and frequent examinations by different people.
- Women in rural areas appreciated not having their husband around during delivery; Beirut women’s opinions on this were mixed.
- All women wanted to see their babies immediately after delivery and continuously or frequently afterwards, but many were not allowed to see their babies for hours or even a day.
- Some hospitals actively discouraged breastfeeding in additional ways, asking the family to bring a bottle and formula for the baby.
- In rural areas, women felt that post-partum check-ups were only necessary when there were problems.
- In Beirut, almost all women made post-partum appointments with the obstetrician before leaving the hospital.

Lebanese women were passive regarding medical interventions and technology, but were also unhappy with some of the procedures.

Phillips, Daphne

1996 Medical Professional Dominance and Client Dissatisfaction. *Social Science and Medicine* 42(10): 1419-1425.

Combining participant-observation, behavior observation, and survey research techniques, the author examined the relationship between medical professional dominance and reported satisfaction with care among 320 obstetric and gynecology in-patients in four public hospitals in Trinidad and Tobago. In order to take part in the study, patients had to have been in the hospital for more than three days, which may have biased results, as normal deliveries might not be expected to require more than three days of hospitalization.

Of the physicians observed, 95% were male. The majority of the patients (60%) had incomplete secondary education. Over 20% of the sample had completed secondary education or post-secondary/university. No one was illiterate.

“Professional dominance” is a widely used concept in medical sociology. The author defines “professional dominance” as consisting of three elements:

1. Professionalism (i.e., “the ability of a profession to control all aspects of its functioning including the selection of recruits, the setting of standards for curriculum and training, the determination of its fee structure, its clientele and the specific types of activity which fall in its domain.” (1419)
2. Control over other professions
3. Social control.

Professional dominance is expressed in the physician/patient relationship through social control. The author observed the following examples of social control: poor communication initiated by the physician, reluctance to give information to the patient about her own condition, use of jargon in conversation with the patient or about the patient in her hearing, and evasion of the patient’s direct questions about her condition. The author noted that, in general, patients often fear and dread attempting to communicate with the physician in a meaningful way. In this situation, patient satisfaction tends to be low, and patients report that they are afraid to ask the doctor questions about their condition or perceive that the doctor is too busy to answer.

The result of this asymmetrical relationship has been reported to be “a sense of mistrust and of suspicion of medical decisions” (1419). In a study of patient satisfaction in U.K. hospitals, J. Skipper reported that poor communication between physicians and patients resulted in:

1. Less cooperation by patients
2. Less confidence in physicians by patients
3. Greater probability that physicians would base their actions on misperceptions of patient needs.
4. Less probability that the patients’ fear and anxiety about their conditions would be reduced.

Phillips measured patient satisfaction through the following dimensions:

1. Patients reports of mistrust or suspicion of physicians' decisions
2. Patients reports of perceived negligence by physicians
3. Patients' reports of poor communication and/or lack of information (1421).

All of these dimensions were derived from survey responses, which were analyzed on a scale.

Phillips' results include the following:

- Observation showed that almost 95% of communication between doctors and patients was either poor, very poor, or absent entirely.
- There was "excessive use" of jargon.
- Most patients were unable to state or explain their diagnosis.
- The educational level of the patient did not affect the amount (or lack) of information she received.
- There was no correlation between level of satisfaction and educational level.
- 75% of patients were at least somewhat dissatisfied.
- 59% of patients were suspicious about the quality of the care they received from doctors
- There was evidence of disregarding patients' statements and observations about their own conditions, leading to malpractice by physicians.
- Patients reported being treated much better in private clinics than at the public hospital, even by the same physician.

Roberts, Carlos A. and Mara S. Aruguete

2000 Task and Socioemotional Behaviors of Physicians: A Test of Reciprocity and Social Interaction Theories in Analogue Physician-Patient Encounters. *Social Science and Medicine* 50(2000): 309-315.

This study divides physician behavior into "task behavior" and "socioemotional behavior," concepts that appear in much of the literature on provider behavior. Task behavior consists of instrumental actions that accomplish medical goals, including providing health information. Socioemotional behavior consists of actions that accomplish interpersonal goals. Other studies indicate that socioemotional behavior plays the largest role in patient satisfaction in the West. Studies also suggest that the importance to the patient of physician socioemotional behavior decreases as education increases. A review study found that physician socioemotional behavior tends to predict patient satisfaction, while task behavior (information giving and question asking) tends to predict patient compliance and recall.

The purpose of the study was to test in a laboratory whether patients recognize and react primarily to socioemotional behavior or whether they recognize and react to both task and socioemotional behavior. Researchers showed four videotapes of a physician (actor) which varied from low to high task and socioemotional physician behavior. In all videotapes, the "physician" named the diagnosis-- diabetes, prognosis, prescribed medicine, and recommended lifestyle changes.

Researchers recruited 93 participants recruited from the waiting room in a student health service of an historically Black college in the U.S. All participants viewed all videotapes, putting themselves in the position of patient. They were then asked to rate the physician on Likert-type scales of patient satisfaction, willingness to self-disclose symptoms and fears to a physician, trust in the physician, likelihood to recommend the physician to others. All of these were considered indicators of socioemotional behavior. Participants were also asked to use Likert-type scales on their feelings about motivation to comply with the physician's directions, and a short open-ended questionnaire measuring recall of information that the "physician" provided. These were grouped as measures of task behavior.

Results indicated that in the tapes where the physician demonstrated high socioemotional behavior, participants rated themselves higher on satisfaction and trust of the physician. Participants also rated themselves more likely to disclose to the physician and to recommend him to others. Rankings of motivation to comply with treatment were not affected. Similarly, recall of accurate information was not affected. Unlike some other studies, high physician task behavior videos also did not affect ranked motivation to comply or ability to recall medical information.

Effect of Communication on Health Outcome:

Kaplan, Sherrie H., Sheldon Greenfield, Barbara Gandek, William Rogers, and John E. Ware, Jr.

1996 Characteristics of Physicians with Participatory Decision-Making Styles. *Annals of Internal Medicine* 124(5):497-504.

The authors analyzed a portion of data from a much larger survey of U.S. patients, the Medical Outcomes Study, to identify characteristics, both of the physician and the practice setting, that supported the tendency of physicians to accord patients a role in making decisions about their own health. The sample included 7,730 patients of 300 physicians (none of whom was a gynecologist). Almost 84% of the physicians were male, over 61% of the patients were women. Physicians filled out background questionnaires; patients filled out detailed questionnaires covering many topics.

Satisfaction with the physician was associated with better medical outcome for the patient. Satisfaction with the physician was correlated with the patient's perception that the physician had a participatory decision-making style. Patients who perceived that the physician was not participatory (those in the lowest 25% in participation) were twice as likely to change physicians within a year as those who perceived that their physicians were very participatory.

Key findings regarding physician attributes included:

- Physicians who had been trained in counseling and interviewing or primary health care in medical school, even if the last encounter with such training had been 10 years ago or more, were more likely to have a participatory style.

- Physicians who perceived that they had professional autonomy were more likely to have a participatory style and higher levels of patient satisfaction.
- Physicians with the highest volume of patient visits were least likely to have a participatory style and more likely to have lower levels of patient satisfaction.

DiMatteo, Robin M.

1994 The Physician-Patient Relationship: Effects on the Quality of Health Care. Clinical Obstetrics and Gynecology 37(1): 149-161.

The author summarized the state of knowledge about the physician-patient relationship in gynecology and obstetrics, based on studies primarily from the U.S. Starting from the premise that the physician-patient relationship is based on communication, the author noted well-researched consequences from failures in communication between providers and patients, as well as benefits to good communication.

Studies have shown an association between good patient/physician communication and outcome measures, such as

- Improved recovery from surgery
- Decreased use of pain medication
- Shortened hospital stays
- Improved physiologic changes in blood pressure and blood sugar
- Improvement in symptoms and better management of chronic illnesses
- Less delay in reporting important symptoms.

On the negative side, poor physician/patient communication has been associated with:

- Patient dissatisfaction often leading to termination of the patient/physician relationship
- Poor adherence to therapeutic regimen
- Incorrect diagnosis and treatment due to insufficient or misleading information
- Uninformed consent.

Difficulties in physician-patient communication include:

1. Physicians speak in jargon patients don't understand.
2. Physicians spend little time listening to patients and tend to limit patients' communication to information (due to time pressures).
3. Information that patients want is not provided by the physician.
4. Physicians and patients have very different beliefs about what patients need to know about treatments and procedures.

The author traces the reasons for these difficulties to:

- The invention and widespread use of antibiotics which turned physicians' attention toward the germ and away from the person.
- Medical education tends to diminish people's communication skills (studies indicate that there is an inverse relationship between year in medical school and ability to talk

with patients); the physical and emotional brutality of medical training decreases empathy for patients.

- The current structure of the medical system makes it very difficult for patients to maintain their autonomy, e.g., patients don't have the same access to the breadth of medical knowledge or ability to understand implications of the knowledge.
- Most gynecologists/obstetricians are men and studies show that the most problematic patient-doctor relationships are between male physicians and female patients.
- The possibility of conflict between the recommendations of the physician and desires of the patient is often not mentioned by either party; therefore, it never gets addressed.

In the U.S., research indicates that “patients ... want to be able to trust the competence and truthfulness of their care givers and to be treated with dignity and respect. Patients want to know how their sickness and treatment will affect their lives” (154).

The conclusion of the review is that in the most effective relations, physicians and patients share power and control of the health care decisions. Therefore, the author advocates for a model of “collaborative informed choice”:

1. Patient and physician define the problem and each voice their expected outcome.
2. They discuss the goal outcomes and assure that their views are mutually and fully understood.
3. They discuss potential effect of alternatives for dealing with the problem and achieving the outcome goals.
4. Through negotiation, the physician-patient pair reaches a joint decision to try one of the alternatives likely to accomplish the goals.

To do this, physician has to provide much more information than is now usually the case.

A behavioral model is needed to achieve collaborative informed choice:

1. Physicians need to let patients tell their stories and physicians need to respond with empathy and concern, conveyed through non-verbal communication.
2. Providers should encourage patients to ask questions.
3. Providers should provide information to all patients in ways that patients can understand.
4. Physicians should explore every patient's health goal and outcome expectations and should respect the patient's health goals and values (although the doctor may have to help the patient to adjust these if unrealistic or dangerous).
5. Patients need to receive help in organizing the information they receive (e.g., co-writing the medical record).
6. Another way to organize information: PREPARED for Healthcare: Procedure (indication), Reason, Expectation (expected outcome or benefit), Probability (of achieving this outcome), Alternatives, Risks, Expenses (direct and indirect), Decision.
7. Don't ask the patient to make any major decisions in a non-emergency situation during one office visit; schedule a second visit after the patient has had time to think and talk with family and friends.

Conclusions

Many themes relevant for Egypt emerge from the literature:

- In many contexts, including Egypt, professional dominance and professional autonomy are key to physician satisfaction.
- How a physician communicates with the patient and her family can influence the patient's health outcome.
- Results are mixed on the effect on patient "compliance" of giving medical information to patients in a didactic way.
- Women in the Middle East tend to prefer female providers for the sake of their own modesty, but male providers for the sake of the providers' skill.
- In the U.S., the male provider/female patient dyad is the most problematic combination.
- In many countries, the same physician treats his/her private patients better in his/her own clinic than s/he does in the public hospital; but the physician's private patients are treated better in public hospitals than patients who are admitted through the public clinic.
- The socioemotional aspect of health care is very important in the Middle East, but its importance can be confounded by practical considerations (e.g., when the patient's time is very valuable or she is pressed).
- Culture change regarding the importance of antenatal and postpartum care seeking by patients has been documented in the Middle East, as demonstrated by the Lebanese example.
- Egypt's problems with physician satisfaction, performance, and systemic problems of the health care system seem to be of relatively long duration and have been of concern to the Egyptian MOH for some time.
- Many of the behavioral issues that have been observed in Egyptian physicians are not specific to Egypt, but are found much more widely.
- Physicians should be trained to be heads of their team, which includes nurses and paramedical personnel.
- Physicians should be trained to train nurses.
- In Upper Egypt, the professional and personal worlds are not as separate as in the West and subordinates' family position and strength, and the importance of their patrons inhibits the physician's authority (reading between the lines of El-Mehairy's study)..
- In Egypt, the public sector, but especially the private sector, needs training and supervision in patient record keeping.
- Good communication between physician and patient seems to depend on professional autonomy of the physician and physician training in socioemotional skills or interviewing.

RECOMMENDATIONS BASED ON THE LITERATURE AND CONVERSATIONS WITH HM/HC STAFF AND CONSULTANTS

The strongest factors that affect provider behavior appear to be:

1. Insufficient professional autonomy, coupled with insufficient support as a professional, leading to problems such as: problematic relations with paramedical staff; physicians' outside Cairo and other major cities feel abandoned or punished; inability to keep up to date with the latest medical procedures and findings;
2. Insufficient training in: socioemotional aspects of health care, team work, some task behaviors (e.g., patient counseling), and national standards of medical ethics
3. Insufficient monetary compensation, leading to: under-the-table charges which are neither regulated nor standardized; reliance on private practice for income, which leads to different standards of care for private patients vs. those admitted via public sector clinics, failure of public physicians to be at hospitals during working hours because they are busy in private clinics, as well as private physicians' reluctance to send women delivering in their clinics to the hospital early enough to save them
4. Physicians directly out of residency/internship put in a situation with a great deal of responsibility and insufficient clinical experience
5. Nurses inadequately trained to assist physicians in emergency situations or play a leading role in infection control and other care
6. Other hospital staff members inadequately trained in their role in infection control and saving women's and babies' lives.
7. History of problems with teamwork that is essential in medical emergencies
8. Relationships of physicians to the community differ in Upper Egypt from other parts of Egypt, sometimes leading to problems in managing hospital and clinic staff from powerful families, or staff problems in relating to physicians from outside Upper Egypt.
9. Low levels of professional autonomy, leading to lower morale and resulting in poorer patient care and perhaps higher levels of absenteeism.

Healthy Mother/Healthy Child already works on most of these issues. For example, the Community Health Committees and District Health Committees directly address the relationship of communities to the physicians who serve them. The project has been working with university professors on national standards of professional ethics. HM/HC has also been training physicians and nurses. The project has developed an activity to link district hospitals with medical faculties of universities.

The following behaviors/behavior complexes that result from these eight factors are problematic and amenable to "improvement" through work with CHANGE:

- Teamwork
- Task behavior re. patient education and infection control (e.g., informing patients and families about procedures before they are carried out; meeting MOHP infection control standards)

- Socioemotional behavior by physicians, nurses, and others on the obstetrical and neonatal teams (e.g., encouraging patients, reassuring patients and families, expressing caring)
- Professional dominance by physician on team, with open communication and input from other team members
- Increased professional autonomy of physicians through increased communication and management skills and striving for model hospital status.

Suggestions for Addressing Behavioral Issues

- Teamwork
 - Written job descriptions known and understood by all on team (prerequisite to behavior)
 - Team members (nurses, cleaners, clerks, other paramedical personnel) perform the tasks specified in their job descriptions without frequent reminders and proactively act to handle emergencies without exceeding the limits of their knowledge.
 - Team members accord the physician professional dominance within the team.
 - Physician and nurses give orders clearly and appropriately to others on team.
 - Team discusses and resolves problems openly among team members
 - Team discusses cases where team functioned well and outcomes for mother and baby were good; discussion includes what everyone on team did and why everything went right (appreciative inquiry)
 - Team discusses “near miss” cases where outcome was good, but team did not function well; discussion includes how to fix what went wrong and reasons for good outcome in spite of mistakes.
- Physicians trained in patient and family member counseling, task behavior and patient education, socioemotional elements in clinical care and their relation to patient outcome, through assistance with ongoing HM/HC communication training
- Nurses trained in socioemotional elements in clinical care and their relation to patient outcome, and in patient education through assistance to ongoing HM/HC training and nursing school curriculum revision
- All other members of obstetrical and neonatal teams trained in communication with patients/patients’ families
- All members of team trained in hierarchical teamwork by Egyptian management specialist
- Model hospitals (like Gold Star program for family planning) that practice all components of the “teamwork package.”